



COMMUNICATION AND TREATMENT PREFERENCE ASSESSMENT

This assessment tool will enhance the partnership between you and the ALS Clinic Team and will help us to better understand your treatment preferences.

PATIENT INFORMATION

PATIENT NAME: _____

CLINIC DATE: _____

LEGAL DOCUMENTS

Do you have a:

- Financial Power of Attorney
- Health Care Power of Attorney
- Advance Care Directive
- Living Will
- POLST (Physician Orders for Life Sustaining Treatment)

Do you want more information about these documents?

- Yes
- No

INFORMATION/COMMUNICATION

1. Decisions will need to be made about your treatment choices in ALS.

Please check which you prefer. I prefer to:

- Make decisions together with the medical staff
- Make decisions together with my family (or a person whom I trust) and the medical staff
- Delegate decisions to the medical staff
- Delegate decisions to my family (or a person whom I trust) and the medical staff

Other (please explain below):

2. If I cannot make health care decisions on my own, I am delegating decision making to:

Please provide person's name:

Please identify your relationship with this person:

3. What are your treatment goals at this time?

- Extend life at all cost
- Extend life with selected treatments
- Comfort, not extension of life
- Other:

Is there anything that we could do to be helpful for you as you think about these questions?

TREATMENT AND SYMPTOM CONTROL



4. Some people like to receive a great deal of information, others want basic information. What kind of person are you?

- Detailed Information Basic Information

5. ALS produces changes that may require specific treatment. Given your goals for care, would you like to discuss these with your ALS team?

- Feeding Tube Diaphragm Pacer Ventilator Support Respiratory support by a mask
 Resuscitation/CPR Experimental/Research

6. Are there any needs or services that you feel you need to discuss right now?

- Yes No

What are they?

7. If your condition should worsen to the point where your life expectancy would be short, would you want to know?

- Yes No

Who else may we communicate with?

LIVING WELL

8. What fears or worries do you have right now or about the future?

9. Who or what sustains you when you face serious challenges in your life?



10. In what way do you feel you could make this time especially meaningful to you?

11. For those closest to you, what do you most hope for?

Staff Review (For Office Use Only)

Staff Review: _____ Date: _____

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